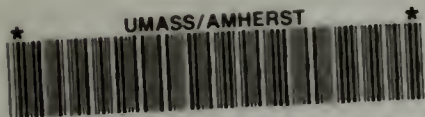


MEDICAID AND THE MASSACHUSETTS HEALTH SYSTEM IN FY91

RECOMMENDATIONS OF THE HOUSE COMMITTEE ON WAYS AND MEANS

May, 1990



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EXECUTIVE SUMMARY

Medicaid was projected to grow an astounding \$700 million in FY91, by 33 percent over FY90 spending, when the House Committee on Ways and Means began its budget drafting process in February. Concerned with the implications of this growth, and the Commonwealth's ability to afford it, Committee Chairman Richard A. Voke appointed a three-member subcommittee to examine Medicaid spending. The subcommittee met twenty times for more than sixty hours to develop recommendations that are incorporated in the Committee's budget, House 5700. The following explains the rationale and effects of these recommendations for Medicaid and the Commonwealth's citizens in FY91.

FY91 APPROPRIATION RECOMMENDATION

The Committee recommends a \$2.453 billion appropriation for Medicaid in FY91, which is about 15 percent higher than anticipated FY90 spending of \$2.135 billion. The Committee projects that spending would reach \$2.825 billion next year if no reform of the program occurred. The Committee has reduced projected spending through a savings and reform package in its budget that is worth \$332 million. The Committee also authorizes the program to spend \$40 million in retained revenue.

The Committee's Medicaid spending authorization in FY91 is \$404 million above the Governor's House 1 recommendation, primarily because the Committee restored many of the more severe cuts to program benefits and entitlements made by House 1. The Governor's budget, it should be noted, provided Medicaid with at least \$46 million less in FY91 than this fiscal year.

The Committee believes its recommended appropriation is realistic and fiscally honest. It is not inflated to justify new taxes nor does it underfund Medicaid, which in past years, has routinely haunted the legislature in the form of supplemental budget requests.

The Committee's budget also recognizes Medicaid's past due liabilities by creating a separate line item of \$68.2 million for retroactive payments owed to hospitals and nursing homes. This recommended amount, which is reflected in the total appropriation, makes it easier to hold the program accountable for such payments, although this amount falls short of Medicaid's total outstanding accrued liability to health care providers.

The Committee believes a realistic appropriation is necessary to prevent further chaos in a year of unpredictable revenues. The Committee recognizes that Medicaid is a commitment of the state to its poorest citizens and, as an entitlement program, cannot morally and legally be underfunded. The Committee cautions that this appropriation depends on new revenues, without which, major cuts in benefits and the termination of Medicaid eligibility for thousands of people will be necessary.

MEDICAID BUDGETING ASSUMPTIONS

The Committee's appropriation level and savings and reform package relies on the following principles that were established by the Ways and Means subcommittee on Medicaid.

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1. Medicaid spending growth cannot continue indefinitely nor can it remain isolated from other state health spending or state oversight and regulation of the health care system.
2. Long term care spending now exceeds \$1 billion and is Medicaid's major cost center. Spending in this area will increase exponentially as the Commonwealth's elderly population grows over the next decade. These services must be delivered more efficiently by a system that can coordinate senior care in the most cost-effective settings.
3. Factors that contribute to Medicaid cost increases, including utilization rates, provider efficiency and reimbursement rates, must be better managed to achieve economies without diminishing quality.
4. Information about Medicaid spending and utilization patterns must be available to enhance program management and promote public accountability.
5. The Commonwealth's fiscal problems make it necessary for all persons touched by Medicaid -- beneficiaries, health care providers and administrators -- to share in the belt-tightening in FY91.

Although the Committee recommends significant changes in the program, the Committee does not take the drastic step of terminating benefits and eligibility for thousands of individuals. The Committee in fact restored many of House 1's severe Medicaid cuts to ensure that:

- 7,000 new admissions to intermediate care facilities -- the Level III nursing homes -- will not be diverted to unknown settings beginning July 1;
- current Level III residents will not suffer the fear of displacement that was threatened by proposals to force these homes to close, downgrade to rest home status or make questionable investments in staffing and capital to upgrade;
- nearly 5,000 disabled individuals will not lose access to essential health care services under the proposal to eliminate the medically needy spend down category of assistance;
- chronic hospitals serving moderately ill patients will not be forced to downgrade to nursing home status;
- numerous optional benefits including optometry, psychiatric day treatment and community mental health for persons under 21 will not be denied to 450,000 beneficiaries; and
- families will not be forced to contribute ten percent toward the cost of their parents' nursing home care.

Although adoption of any or all of these House 1 cuts would save money, the Committee believes that even in the midst of funding problems the citizens of the Commonwealth remain compassionate to want the continued funding of these health care benefits for the elderly and the poor.

CONSOLIDATION OF HEALTH SPENDING AND OVERSIGHT

Foremost among the Committee's recommendations is the restructuring of the Commonwealth's health care purchasing and regulatory system. Control and accountability for these functions is currently disbursed among a half dozen agencies united loosely under the Executive Office of Human Services umbrella. Coordination among these agencies is sporadic at best; often, they work at odds on state policy and fiscal needs.

Because state health care costs have been the fastest growing sector of state spending in the past decade, the need to control these costs during an era of government retrenchment has never been more paramount. The beneficial effect of consolidated spending and policy-making is not limited to the state either. All private sector health care purchasers and health care providers are frustrated by the status quo. Not only taxpayers but private businesses are burdened by the effects of an inefficient, unaccountable system for state health care decision-making.

The Committee thus proposes the creation of a single Department of Health, under a single commissioner, that can integrate state health purchasing, coordinate state health planning, achieve administrative efficiencies and be more responsive to both public and private sector needs. The single commissioner will replace the current system of relying on six independent agency heads and be able to exercise direct authority over policy agendas to ensure the coordination of different functions within the new health department. This consolidation benefits Medicaid by creating direct links to spending and policy decision-making which directly affect the program's costs.

The Committee does not unrealistically expect consolidation to take place overnight. The proposal calls on the next Governor to appoint the new commissioner in January, at which time the commissioner will assume direct line authority over existing agencies. During the initial months of this arrangement, the commissioner is directed to develop a blueprint for achieving the Department of Health's ultimate consolidation. The Committee places extreme emphasis during this transitional phase on ensuring that existing services are not disrupted and that consolidation decisions are not made haphazardly.

Permanent consolidation of the new department will take place once the new Governor and the Legislature act on the commissioner's blueprint, which the Committee hopes for by FY92. The Committee rejected the option of simply rearranging existing agencies because it would not improve state accountability and control in the long run, even if it appeared to do so. The challenge before the Commonwealth is to achieve real savings and efficiencies in the state's health purchasing and oversight functions, which requires a longer vision of the future than a single fiscal year. As a result, the Committee does not count on significant FY91 savings from this transitional phase of consolidation but does expect improved performance in subsequent fiscal years.

LONG TERM CARE RESTRUCTURING

The Committee's second major restructuring proposal also takes effect in January. Since the early 1980's, the Commonwealth's system for delivering long term care to the elderly has been analyzed, criticized, dissected and the subject of numerous recommendations. Today, little has changed, even though spending on long term care has come to dominate state spending and exceeds \$1 billion each year. The Committee proposes a consolidation that puts all state long term care spending in a single division of the new department of health. Money currently spent on home care and home health care through the Executive Office of Elder Affairs will be coordinated with Medicaid dollars spent on nursing home care and home health care. Existing home care corporations will assume single point responsibility for access to this system, including needs assessment, placement in the most appropriate and cost-effective care setting and referral to home health and other home care agencies.

This change may be criticized as an unnecessary departure from past practice. Critics will argue that a little extra work by the status quo system will produce the same savings and efficiencies expected from the Committee's consolidation. The Committee disagrees. Managing scarce long term care resources for a rapidly aging population will be the challenge of the next decade. The current fragmented management of these resources cannot be sustained in the long run, especially as the system's affordability comes under increased scrutiny. Control and accountability within a single state agency must be achieved to overcome past disagreements

over who runs the Commonwealth's long term care system and to move ahead with meeting the future's needs.

In addition to addressing the coordination of long term care services, the Committee recognizes that other aspects of affordability and efficiency must be addressed to control the growth of this major cost center.

PATIENT-CENTERED REIMBURSEMENT

State long term care planning has often been driven by the type of facility and not the type of patient that is under consideration. As a result, nursing homes are treated differently for licensure and reimbursement than chronic care hospitals, another major resource for institutional long term care. Chronic hospitals have a role to play in the health care delivery system but should not be paid considerably more to care for the same type of patient found in a skilled nursing home bed. To make a comparison, the same heavy care patient in a nursing home may be worth \$115 per day, compared with \$300 to \$400 per day in a chronic hospital.

Consequently, the Committee recommends the adoption of patient-centered reimbursement for chronic hospitals. This proposal mirrors the prospective payment system initiated by this Committee in the FY87 budget, which pays nursing homes according to a patient's level of care. (The final phase-in of the nursing home PPS system takes place next January.) The Committee proposes phasing in patient-centered rates over three years, starting with state-owned chronic hospitals in January, 1991, other public hospitals in July, 1991 and private chronic hospitals in October, 1991.

NURSING HOME ELIGIBILITY AND ADMISSIONS CRITERIA

As noted earlier, the Committee restored funding for Level III nursing homes in FY91. The Committee also restored \$9 million in funding for home care that will assist over 3,100 senior citizens remain in their homes and avoid institutionalization. Nevertheless, spending on nursing homes cannot continue unabated or the system will be truly unaffordable.

Money alone will not create a more rational, efficiently delivered long term care system. The Commonwealth, as payer of most nursing home bills, must require that nursing homes meet the health care demands of a rapidly aging, increasingly frail and sicker elderly population. The ability of many nursing homes to meet this expectation is questionable. At least 100 of the state's 550 homes, for example, are grandfathered from current life safety code standards. The future of these homes needs resolution, which the Committee believes should be planned systematically to meet the needs of current residents, the transition needs of facilities that might close or convert to other uses and new demands that might be placed on the community care system. Consequently, the Human Services Secretary is directed to develop a plan that addresses these problems by March 31, 1991.

The Secretary is also asked to address in this plan the need to ensure that all nursing home placements meet the changing demographic and medical needs of senior citizens. The Secretary's plan is expected to recommend revisions to nursing home eligibility and admissions standards and to identify the resources necessary to make additional community care available to individuals who may be ineligible for nursing home placement.

Among the more difficult budgeting tasks of the Committee was finding ways to save money or avoid costs in an era of severe belt-tightening. Medicaid's nursing home benefit has become viewed as an entitlement program for all of society which is at odds with Medicaid's original purpose of assisting the poor. With nursing home stays costing taxpayers an average of \$22,000 per resident, the need to ensure maximum cost savings becomes evident.

Thus, the Committee requires nursing homes and chronic hospitals to continue seeking maximum reimbursement from the federal Medicare program. In another effort to tap federal dollars, the Committee's only staffing increase in the Medicaid reform package would add three

eligibility officers to the Office of Veterans Services whose sole job consists of enrolling veterans, their spouses and dependents in a federal nursing home benefit program. The \$150,000 cost of the program is expected to produce net savings of more \$6 million to Medicaid.

In a similar vein, the Committee embraces the controversial but necessary proposal to avoid Medicaid costs when substantial assets such as ownership of a home could be used as a payment source for nursing home care. The Commonwealth has among the least restrictive nursing home eligibility and placement criteria of any state in the country. As a result, the Medicaid program pays the cost of 75 percent of nursing home residents and covers 35,000 of the state's 45,000 residents.

The Committee projects that counting the house as an asset for Medicaid spend-down eligibility will not affect the vast majority of nursing home residents yet can still save the program \$30 million in FY91. Savings of this magnitude are difficult to achieve in an entitlement program but not taking this step makes it much more difficult to fund other priority programs, such as preserving the Level III nursing home benefit for the majority of seniors and paying the state supplement to SSI beneficiaries.

Under the proposal, the house is not a countable asset whenever the nursing home resident is likely to return to the home or when the resident has a spouse, disabled dependent, co-owner sibling or long-term caretaker living in the home. These strict limitations on the state's ability to count the house are prescribed by federal law. The Committee added yet another exemption to this proposal by allowing residents with long term care insurance to preserve their home. The Committee's interest in preserving the integrity of basic nursing home benefits under Medicaid required that this one, single eligibility restriction be recommended in its Medicaid reform package.

OTHER COMMITTEE RECOMMENDATIONS

The Committee recommends many other changes that address the accountability of Medicaid's management systems and the program's controls over service utilization, reimbursement rates and provider efficiency. A series of accounting and management information reforms are recommended to enable Medicaid managers and the public to better understand the costs and utilization of Medicaid services. An accounting and performance audit is funded to give the next Governor and Health Commissioner a basis for initiating further reform in these areas.

The Committee set a deadline of January 1992 for enrolling all beneficiaries in managed care plans which are appropriate to their medical and demographic needs. Medicaid's fee-for-service system creates no incentives for beneficiaries to control costs nor does it encourage providers to deliver the most cost-effective services. Medicaid is directed to examine HMO's, primary care case management, high cost case management and other managed care options to assure beneficiaries of access to high quality services and to create accountability for spending growth.

The program is directed to use its selective contracting powers, created by the Budget Control and Reduction Act of 1989 (Ch.653), to contract for high tech, high cost acute hospital services and to use competitive bidding to obtain pharmaceutical savings.

As noted above, the Committee recognizes that Medicaid's affordability problems in the coming fiscal year require belt-tightening by all parties affected by the program. Thus, the Committee expects the program to achieve a \$100 million reduction in rate increases to health care providers that had been projected to increase by \$240 million. This will bring rate increases more in line with general inflation rates and not with medical inflation rates.

THE HISTORY OF THE UNITED STATES

The history of the United States is a story of growth and change. It begins with the first settlers who came to the Americas in search of a new life. They found a land of opportunity, but also a land of challenges. The early years were marked by conflict and struggle, but the spirit of the American dream prevailed.

As the colonies grew, so did the desire for independence. The British government's policies of taxation and control led to a growing sense of resentment among the colonists. They fought for their rights and eventually won their freedom. The new nation was born, and the path ahead was uncertain.

The early years of the United States were a time of exploration and discovery. The nation's borders expanded, and new territories were added. The people of the United States were united by a common purpose and a shared vision of a better future. The challenges were great, but the determination was even greater.

The United States has come a long way since its founding. It has grown from a small colony to a global superpower. It has faced many challenges, but it has always emerged stronger and more united. The American dream is still alive, and the future is bright.

The history of the United States is a testament to the power of the human spirit. It is a story of hope and resilience, of courage and sacrifice. It is a story that inspires and motivates, that gives us a sense of purpose and direction. The United States is a land of opportunity, and the future is ours to shape.

The United States is a land of diversity and inclusion. It is a place where people from all backgrounds and cultures can thrive. It is a place where the American dream is a reality for everyone. The United States is a land of promise, and the future is bright.

The United States is a land of freedom and justice. It is a place where the rights of all people are protected and valued. It is a place where the American dream is a reality for everyone. The United States is a land of promise, and the future is bright.